This appeal arises under the Texas Workers' Compensation Commission Act of 1989, TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 *et seq.* (Vernon Supp. 1992) (1989 Act). A contested case hearing was held in (city), Texas, on December 30, 1991, at the request of claimant (claimant below) with (hearing officer) presiding as hearing officer. According to the Benefit Review Conference Report made a part of the hearing record, the sole disputed issue was whether claimant was entitled to additional income benefits. The Benefit Review Officer recommended that no additional income benefits be paid to claimant since the treating physician had determined that as of June 7, 1991, claimant had reached maximum medical improvement (MMI) with no impairment. This broadly stated issue was also agreed to by the parties as the issue at the contested case hearing.

Claimant contended, in essence, that after her first treating doctor, an orthopedic surgeon, told her in June 1991 that he had done all that could be medically done for her painful right shoulder, which she injured in (date of injury), and would not provide further treatment, she continued to experience pain, disagreed with his assessment, wanted a second opinion, and had to go to emergency rooms for treatment. In October 1991, she eventually persuaded carrier's adjuster to approve her seeing a second treating doctor, also an orthopedic surgeon. The second doctor took her off work for two weeks and prescribed exercises, heat, and some medications, one of which provided some relief. Claimant's shoulder seemed to improve somewhat but she remained under his care. Claimant, who represented herself, did not clearly articulate the theory or bases underlying her contention that she was entitled to additional income benefits nor distinguish between temporary and impairment income benefits. However, her position seemed to be that because she continued to experience pain after the cessation of treatment by her first doctor in June 1991, that doctor, her second doctor, and the emergency room doctors who treated her all should have realized she still had a problem; that in the interim her benefits should not have been stopped; and, that she should therefore be compensated for what she has had to endure because she was still injured. Carrier opposed additional income benefits on two grounds understanding claimant's contentions to be twofold. First, that claimant was entitled to additional benefits because her doctors had placed a 30-pound weight lifting restriction on her work and had restricted her to light duty for a time. Against this contention, carrier argued that claimant's employer provided her an opportunity to continue to work for the same wage with proper observation of the weight lifting restriction but that claimant simply wasn't interested and voluntarily left that employment. Secondly, carrier urged that no additional income benefits (temporary or impairment) be paid because claimant had been certified by her first doctor as having reached MMI without any impairment and also cited the lack of any objective evidence of impairment.

The hearing officer determined that claimant was not entitled to additional benefits after having reached MMI on June 7, 1991, with a zero percent (0%) whole body impairment, although her right to additional medical benefits under the 1989 Act remained unaffected.

DECISION

Finding a need for further development of the evidence as to whether claimant had disputed the MMI determination and further finding an insufficient basis for the hearing officer's determination that claimant reached MMI with a zero (0) percent whole body impairment rating on June 7, 1991, we reverse and remand.

Claimant commenced work for (Employer) in February 1991 as a member of the housekeeping and cleaning staff at (Hospital 1) in Beaumont, Texas. On (date of injury),

while lifting a container of trash she felt pain in her upper right shoulder on the back side. According to the medical records introduced by claimant, she went to the emergency room (ER) at Hospital 1 on April 8, 1991, complaining about her shoulder. She was diagnosed as having "myositis of the back." Pain and muscle relaxant medications were prescribed, and claimant was told to be off work for three days, rest, and apply heat. Chest x-rays were normal. She visited the ER at Hospital 1 again on April 10, 1991, and saw a different doctor. His diagnosis was "myalgia" and claimant was found to have a pulled muscle. Physical therapy was prescribed in addition to heat and medications. Claimant understood from the doctors that she had a "torn muscle." Claimant testified that she then decided to consult with (Dr. D), an orthopedic surgeon. She selected Dr. D because she had heard of him at work. Dr. D's medical records on claimant were not introduced. Claimant was apparently under Dr. D's care for approximately two months and saw him five or six times from April 24 through June 3, 1991. On April 24, 1991, the apparent date of claimant's first visit, Dr. D signed an "Initial Medical Report" on claimant which contained a diagnosis of "lumbar strain - thoracic spine," noted her prior medications and physical therapy for a week with minimal improvement, and her complaints of pain. The x-rays he ordered were within normal limits and his treatment plan was "conservative." According to claimant, Dr. D prescribed medications and sent her for physical therapy for two weeks. Later, he gave her injections and he obtained an MRI on June 3, 1991, which was normal.

On April 30, 1991, claimant visited the ER at (Hospital 2) complaining of right shoulder pain relating back to her (date of injury), injury. According to a record of this visit, Dr. D was in surgery at the time. A medication was prescribed and claimant was given a sling, told to continue on her medications (which she described as pain killers and muscle relaxants), and was advised to follow-up with Dr. D. On May 4, 1991, claimant returned to the ER at Hospital 2 for a recheck and was apparently given an injection.

Both parties introduced a one-page preprinted form entitled "Report of Medical Evaluation" (TWCC-69). This document pertained to claimant, bore Dr. D's name and address, and contained the following narrative history:

> This patient was seen for two months. She strained some sort of soft tissue in the right rhomboid area. Now she has complaints going all the way to the top of her head to the bottom of her feet. She has recently had cervical and thoracic MRI's. Both of these are within normal limits. My impression is that this patient has reached the point of maximum medical benefit and I am going to go ahead and release her without any permanent disability and I ahve (sic) given her a release to return to work.

This TWCC-69 stated that claimant had reached MMI on "6/7/91" and the percentage of whole body impairment rating was stated as "no disability." The two copies of this document in evidence were not signed by Dr. D although the form contained a block (12) for the doctor's signature. It had the date of June 17, 1991, at the bottom.

Carrier also introduced a document concerning claimant signed by Dr. D on June 7, 1991, which stated claimant was approved for "regular work" and her return to work date was "6/10/91." This document contained no weight lifting or other restrictions on claimant's work. Claimant testified that Dr. D refused to continue to treat her after mid-June 1991; that when she asked him for a different medication, he became rude to her; that he appeared caring initially but became unsympathetic; that he said everything was fine, he had done all he could medically do for her, and she would just have to learn to live with it. After her last visit on June 3, 1991, claimant tried to obtain another appointment with Dr. D but his office

called claimant on June 18, 1991, to advise that
Dr. D would no longer treat her. She attempted to return to work at Hospital 1, worked for a short time, but still had pain and stopped working.

Claimant's medical evidence indicated she again went to the ER at Hospital 2 on July 6, 1991, where she received medication and instruction to follow-up with Dr. D the following week. Claimant testified she visited the ER at Hospital 2, on July 6, 1991, and again in early August 1991, where she was x-rayed, provided with medication, and referred to some doctor (inaudible in record). According to claimant, she commenced discussing her need for additional medical treatment with (BA), an employee of Crawford & Company, the adjusters for carrier. Carrier's adjuster would not, however, approve claimant's seeing another doctor so she simply had to treat herself with a heating pad and over-the-counter medications. On or about September 25, 1991, claimant went to the ER at (Medical Center) but could not obtain treatment there because carrier's adjuster had advised that carrier would not pay the bill.

The next item of medical evidence from claimant was an "Initial Medical Report" form (TWCC-61) which referred to claimant's "4-5-91" date of injury and contained a diagnosis of "thoracic sprain." Most of the information on this form, as received in evidence, was illegible including the signature of the doctor. It was apparently signed sometime in September 1991 and no testimony appeared to relate to this particular document, a part of Claimant's Exhibit 3.

Claimant testified that she had various discussions with (Ms. H), an employee of the Texas Workers' Compensation Commission (Commission) in the (city) office, and with BA, in her effort to obtain approval for another doctor to continue treating her. Claimant said she had disagreed with Dr. D and felt she needed further medical treatment. According to claimant, carrier's adjuster eventually did, in October 1991, approve her consulting with Dr. Z. (Dr. A), an orthopedic surgeon. The only record claimant introduced from Dr. A was an undated prescription form of Dr. A's which contained the entry: "Advised rest for 2 weeks - Released to regular work. Dec. 2nd, 1991." Claimant said she took the medications prescribed by Dr. A and believed the last medication helped some. She saw Dr. A three times with the last visit on November 18, 1991. Dr. A took x-rays and prescribed medications, exercises, and use of a heating pad. He advised claimant to take it easy and took her off work for two weeks until December 2, 1991. She had an appointment to return to Dr. A on January 2, 1992. Her shoulder was "feeling a whole lot better until last week."

(Mr. F) testified that he and claimant had visited BA and discussed the note from Dr. A which "prescribed" rest for two weeks and released claimant to regular work effective December 2, 1991. According to Mr. F, BA then advised claimant that the carrier was obligated by law to pay claimant's income benefits for those two weeks because claimant had been excused from work by her doctor and that she would issue a check when her supervisor approved.

Claimant testified she began a job on December 3, 1991, working 40 hours per week as a teacher's aid at a child care center. Witnesses testified that in October 1991 Employer offered claimant the continuation of her employment at Hospital 1 subject to a 30-pound weight lifting restriction at the same wage she had previously earned. After initially declining the offer, saying she wanted to see a doctor, claimant did return to work at Hospital 1 two weeks later for the same wages she had previously earned. According to claimant, however, what her employer told her was that if she didn't come back to work she would be fired. In any event, claimant was retrained by Employer, provided with safety information,

and given tasks at the hospital not involving the lifting of more than 30 pounds. She worked for about one week and then voluntarily left her job claiming she couldn't work any more. Claimant stated she didn't continue working at the hospital because she wanted to follow doctor's orders, not hurt herself, and just chose not to return to work at the hospital.

In her handwritten appeal, claimant states the following:

> In regards to the statement I did request a seckond (sic) opinion for a doctor. And my first hearing I was told that I should not go throught (sic) the hearing because I did not file a letter and I did file a letter and here is a (sic) enclosed copy.

Claimant attached to her appeal document an undated, unsigned handwritten statement, ostensibly that of claimant, to the effect that because she was still experiencing pain, numbness, and stinging and burning sensations, she was seeking medical advice and treatment from another physician as Dr. D had released her to return to work notwithstanding her continued pain. This statement was not made a part of the record below and cannot be considered as evidence on appeal. Article 8308-6.42(a) (1989 Act). However, we note that during the hearing, the hearing officer specifically discussed the question of Dr. D's determination of MMI with claimant and asked her what steps claimant had taken, if any, to dispute the MMI determination. Carrier objected to the hearing officer's question. However, the hearing officer had a duty to preserve the rights of the parties and ensure the full development of facts required to make his determinations. See Article 8308-6.34(b) (1989 Act). Claimant testified that after Dr. D refused to continue treating her, she called BA and was told to write a letter to her. Subsequently, BA told claimant to send the letter to the Commission which she did. The hearing officer then asked claimant if she had a copy of the letter with her to which claimant replied that, although she had a copy of it at home, the letter "should be here" since she had hand-delivered it to the Commission. The hearing officer then asked claimant if she remembered "whether you just said you needed to see a doctor or whether you specifically said that you hadn't gotten as much better as you were going to get." Claimant responded that her letter recounted that Dr. D had been her treating physician, that she had not gotten better, and that she felt she needed a "second opinion." The written statement claimant has attached to her appeal may be the letter claimant was describing. As we have noted, however, it did not become a part of the hearing record. It is apparent that the hearing officer was attempting to determine whether claimant had attempted to dispute Dr. D's determination of MMI or whether claimant was simply seeking further medical treatment.

Claimant also attached to her appeal five letters from (RR) written during the period from July 11 to September 11, 1991, to Ms. H at the Commission's office in (city), Texas, to Ms. A (sic) at Crawford & Company in (city), Texas, and to Dr. A. Also attached was a letter to RR from BA of Crawford & Company dated August 2, 1991. Apparently, during this period RR represented claimant. The subject of these letters concerned for the most part claimant's request for a subsequent treating physician and whether or not Commission approval was required before carrier could be required to pay for same. These letters were not a part of the record developed below and may not be considered by us. Article 8308-6.42(a) (1989 Act).

Articles 8308-4.23(a) and (b) provide that an employee "who has disability and who has not attained maximum medical improvement is entitled to temporary income benefits . . .", and, that "[t]emporary income benefits continue until the employee has reached maximum medical improvement." As for recovery after MMI, Article 8308-4.25(a) provides that "a

claimant is not entitled to recover impairment income benefits unless there is evidence of impairment based on an objective clinical or laboratory finding . . ."

Article 8308-4.25(b) provides that "[I]f a dispute exists as to whether the employee has reached maximum medical improvement, the Commission shall direct the employee to be examined by a designated doctor selected by mutual agreement of the parties . . . . The report of designated doctor shall have presumptive weight, and the Commission shall base its determination as to whether the employee has reached maximum medical improvement on that report unless the great weight of the medical evidence is to the contrary."

No issue was raised by the parties nor were any findings or conclusions made by the hearing officer regarding whether or not claimant had a "disability" during whatever unstated period of time she claimed her entitlement to additional income benefits. Article 8308-1.03(16) defines "disability" as meaning "the inability to obtain and retain employment at wages equivalent to the preinjury wage because of a compensable injury." Accordingly, we are not called upon to review such issue.

The hearing officer made the following findings and conclusions pertinent to our decision:

FINDINGS OF FACT

3.Claimant's treating physician was [Dr. D] and [Dr. D] certified that Claimant reached maximum minimum medical improvement on June 7, 1991, and had a zero (0) percent whole body impairment rating.

4.Claimant did not dispute the medical findings which [Dr. D] expressed in TWCC 69.

CONCLUSIONS OF LAW

3.Claimant's treating physician certified her as having reached maximum medical improvement on June 7, 1991.

4.Claimant's treating physician certified that claimant had a zero (0) percent whole body impairment rating on June 7, 1991.

In the "Discussion" portion of her Decision and Order, the hearing officer made the following comments:

While it is regrettable that [Dr. D's] assessment of Claimant's medical progress appears to have been erroneous, his findings are binding upon Claimant in the absence of Claimant's proper dispute of these findings. In view of the fact that Claimant apparently did not notify the Texas Workers' Compensation Commission that she disputed the content of [Dr. D's] TWCC 69, but instead indicated that her medical condition had not improved, thus tending to substantiate [Dr. D's] expressed opinion that maximum medical improvement had been achieved, Claimant's subsequent change of treating physician cannot revive her already expired right to receive income benefits.

The hearing officer was advised by claimant that when her treating physician stopped treating her in June 1991, claimant disagreed with his decision to stop treatment, wanted

another opinion, and sought the assistance of carrier's adjuster. BA advised claimant to write a letter about the problem to the adjuster which claimant did. Claimant was subsequently advised by BA to send the document to the Commission and she said she then hand-delivered the document to the Commission. When asked for a copy at the hearing, claimant said she had one at home but that the Commission already had the document. In her appeal, claimant purports to attach the document. The hearing officer was clearly alert to the issue of whether claimant had been disputing Dr. D's determination of MMI or was only seeking additional medical benefits. However, we believe this case should be remanded for the hearing officer's consideration of claimant's written document provided to the carrier and to the Commission and any other appropriate evidence concerning claimant's disagreement with Dr. D.

We further note that neither of the copies of the "Report of Medical Examination" (TWCC-69), offered by both parties contained the signature of Dr. D and no other evidence was adduced to prove that Dr. D had "certified" that claimant had reached MMI. Though a separate determination from that of having reached MMI, we further note that, notwithstanding the hearing officer's finding that Dr. D had also "certified" that claimant "had zero (0) percent whole body impairment rating," the TWCC-69 states the whole body impairment rating as "no disability %." No evidence was adduced to explain what was meant by the term "no disability." Although claimant never articulated whether she was seeking temporary or impairment income benefits, or both, the certification of an impairment rating in terms of a percentage would be relevant. Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(a) (TWCC Rules) provides that a doctor who is required to certify whether an employee has reached MMI "shall complete and file a medical evaluation report as required by this rule." TWCC Rule 130.1(c) requires reports made under the rule to be made on a form prescribed by the Commission. *See* Texas Workers' Compensation Commission Appeal No. 91125 (Docket No. HO-00159-91-CC-1) decided February 18, 1992. The rule also requires the doctor's signature. In the absence of the signature of the doctor purporting to "certify" to claimant's having reached MMI, the evidence fails to support the hearing officer's finding and conclusion in this regard. In sum, whether claimant was certified as having reached MMI and, if so, whether or not she disputed such decision cannot be determined from the record.

The decision of the hearing officer is reversed and the case is remanded for development of appropriate evidence, if any, and reconsideration not inconsistent with this opinion.

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Philip F. O'Neill
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Joe Sebesta
Appeals Judge